happened. And she made the decision to have a autopsy done.

Q. Who made that decision, you, Ms. Wilkey or both?

A. Deb Wilkey did, the coroner. She is the coroner at the time.

Q. Have we covered the extent of your care and treatment of Mr. McKee?

A. I think so.

Q. All right. I don't have any further questions for you, Doctor. Mr. Humphreys may have some.

E X A M I N A T I O N

BY MR. HUMPHREYS:

Q. Doctor, my name's Jim Humphreys. I represent Dr. Bailey, the defendant in this case. In terms of your history -- and if you want to refer back to your history there -- the source of that history was Mrs. McKee; is that correct?

A. The source of the history of what had happened to him prior to his presentation in the emergency department was Mrs. McKee, yes.

Q. And you covered with Mr. Byrd the reason there was an inability to get a CT scan in Lebanon. Could you also recite what Ms. McKee

* redacted *

told you about a follow-up CT?

A. Well, I was given the impression that he -- he had been recommended that he go to another hospital. And I -- and in my discussions with her, I concluded that what she was telling me was in getting a CT scan. But I don't remember the details of that, just that she told me that he had -- had been recommended to go to another facility.

Q. And what else did she tell you about what Mr. McKee decided to do?

A. She told me that he started feeling better and made the decision not to go to the other facility.

Q. Could you just read that sentence that begins with, "However."

A. Well, she gave -- you know, she gave me the impression that he couldn't get scanned there.

Q. Could you just read that sentence?

A. Yeah. It says, "However, he's too large for their scanner table and so had been released with antibiotics and planned to go to another hospital and obtain a CT scan. Decided he was feeling better and did not want to do that."

Q. What was the significance, Doctor, of Mr. McKee's driving from Virginia to Idaho?

A. Well, it's a very substantial driving time from Virginia to Idaho, as you can imagine. And so you're in a vehicle, not moving around very much for long hours. And immobility increases your risk of blood clots and increases the risk of an extending, and so it has obvious risk for clots and pulmonary emboli.

Q. And what is the reason that you recorded in your dictation that Mr. McKee subsequently moved from Virginia to here and did so by driving?

A. Because that was a risk factor for pulmonary embolus and deep venous thrombosis, and it was -- would explain potentially his presentation and current pulmonary arrest.

Q. And in your review of systems, Doctor, you had given an estimate of Mr. McKee's weight. What was that estimate?

A. Greater than 400 pounds.

Q. And is that a measured weight or is that just something you eyeballed?

A. No, that's a guessed weight. It was basically a guess based on his size and his height, apparent height, and just a visual guess. I may have asked her about his weight. I don't remember.

Q. And when you say someone is morbidly obese, what does that mean?

A. I don't recall the actual specific line that gets crossed in terms of body weight that would put somebody in morbid obesity, but he's well above that, well.

Q. But what does "morbid obesity" mean?

A. Extreme, extremely obese.

Q. And what is the significance of that, at least as far as Mr. McKee's death is concerned?

A. It increases the risk of all types of health problems, but in this case, it substantially increases his risk of blood clots and pulmonary embolus.

Q. Now, you had mentioned a D-dimer test?

A. Yes.

Q. That was done at the hospital in Idaho?

A. Yes.

Q. And the level is 32.6; is that correct?

A. Yes.

Q. Am I reading this scale correctly, but is that over 65 times normal?

A. Well, you know, as far as what's normal, the cutoff point for concern is .5. So it is about 64 or five times normal.

Q. In terms of characterizing that as being elevated, is that extremely elevated? Moderately elevated? Just a little bit elevated?

A. That's pretty extremely elevated.

Q. You also mentioned something significant in the history that Mrs. McKee gave you which was Mr. McKee passed out the night before --

A. Yes.

Q. -- he came to see you?

A. Yes.

Q. Or the night before you saw him?

A. Right.

Q. What is the significance of that?

A. Well, it's unusual for somebody to completely pass out who is 31 years of age, and he's having respiratory problems, and that would make me very concerned about pulmonary embolus. Even if he was talking and breathing in front of me, I'd be concerned about that.

Q. Were you ever given any history about Mr. McKee's passing out before the night you saw him?

A. No.

Q. Can you explain how deep venous thrombosis would become a pulmonary embolism?

A. The clots in the deep veins, which is pretty much from about your knees up -- there are some deep veins in the calves, but they don't commonly cause pulmonary emboli. But in the deep veins from your thighs up through your pelvis and abdomen, those clots can travel up, break loose and travel up the central venous, the inferior vena cava, make it to the right heart, get pumped out into the pulmonary arteries where they cause obstruction in the lung tissue.

Q. And long car rides have increased the risk of that taking place?

A. Yes.

Q. Have you ever seen any of the records from the emergency department visit in Lebanon?

A. No.

Q. Were you aware that Mr. McKee had a venous Doppler done in Lebanon which was normal?

MR. BYRD: Objection.

THE WITNESS: No, I have no knowledge --

MR. BYRD: -- 399.

MR. HUMPHREYS: I'm sorry?

MR. BYRD: Objection. 8.01399.

MR. HUMPHREYS: Well, I think his answer is he was unaware, so let me get the answer, and

then it will be subject to your objection, Ben.

MR. BYRD: Sure.

BY MR. HUMPHREYS:

Q. Were you aware that Mr. McKee had a venous Doppler done in Lebanon which was normal?

A. No.

Q. What is the significance of the normal venous Doppler?

MR. BYRD: Objection. 8.01599.

BY MR. HUMPHREYS:

Q. Okay. Subject to that objection.

A. Well, I'm assuming that the venous Doppler would have been done of his lower extremities, which is the most common place for clots. And if that was negative, that would make you less concerned about deep vein thrombosis in the lower extremities at that time, but you wouldn't rule out the possibility.

Q. The possibility of what?

A. Of clots elsewhere.

Q. I think that's all the questions I have, Doctor. Thank you.

E X A M I N A T I O N

BY MR. BYRD:

Q. Just briefly, Doctor. You had testified

that you had not seen the records from the Lebanon hospital. So would it be fair to say, Doctor, that you're unaware of what the diagnosis, if any, was for Mr. McKee when he was at that hospital?

A. Yeah, I don't know anything about the care except that his wife told me he was having some respiratory symptomatology which is why he went there. And that -- and that she said that they had recommended he go to another facility. That's all I know about it is what she told me.

Q. Right. And that didn't include the diagnosis, if any, that he had received while he was at the hospital?

A. Did not.

Q. Is that fair to say?

A. Didn't include any diagnosis. Didn't include any testing they might have done or lab or anything like that.

Q. And as far as the specifics of what Mr. McKee was told as far as under what circumstances he could or could not get the CT, you obviously didn't speak with the doctor who saw him there, so you don't know what the doctor would have to say about that; is that fair to say?

A. Yes. I don't have -- I didn't have any

contact with the physician. I didn't have any access to the records.

Q. And then you don't know whether Mr. McKee was given options about whether to get it or not get it depending on how he felt; is that fair to say?

A. No, I don't know anything about that except what his wife told me.

Q. I don't have any other questions. Thank you.

EXAMINATION

BY MR. HUMPHREYS:

Q. And, Doctor, what did Ms. McKee tell you about why Mr. McKee chose against getting a follow-up CT?

A. She told me that he was feeling better and decided against going to the other facility.

MR. HUMPHREYS: Okay. That's it. You done, Ben?

MR. BYRD: I don't have anything else.

MR. HUMPHREYS: Okay.

THE REPORTER: Are you ordering the transcript?

MR. HUMPHREYS: Well, we have a trial date on December 1, so what's your normal

turnaround?

MR. BYRD: I was going to say, though, Doctor, do you want to read and sign the transcript?

THE WITNESS: Yes.

MR. BYRD: Okay.

MR. HUMPHREYS: Well, Doctor, since you want to read and sign it, could you give the court reporter your address.

THE WITNESS: She has it.

MR. HUMPHREYS: Oh, you know him, huh? He's already given it to you. All right. Okay.

THE REPORTER: Are you ordering the transcript?

MR. BYRD: I am, yes, ma'am.

MR. HUMPHREYS: And I want a copy.

(Exhibit No. 1 marked.)

(Deposition concluded at 11:37 a.m.)

(Signature Reserved)

-oOo-

C E R T I F I C A T E

STATE OF WASHINGTON

COUNTY OF KING

I, Kathleen Hamilton, a Certified Shorthand Reporter and Notary Public in and for the State of Washington, do hereby certify that the foregoing transcript of the deposition of PAUL F. PASCHALL, M.D., having been duly sworn, on JULY 13, 2015, is true and accurate to the best of my knowledge, skill and ability.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 20TH day of JULY, 2015.

KATHLEEN HAMILTON, RPR, CRR, CCR

A C K N O W L E D G E M E N T O F D E P O N E N T

I, PAUL PASCHALL, M.D., do hereby acknowledge I have read and examined the foregoing pages of testimony, and the same is a true, correct and complete transcription of the testimony given by me, and any changes or corrections, if any, appear in the attached errata sheet signed by me.

_____ DATE

_____ PAUL PASCHALL, M.D.

James N. L. Humphreys, Esquire
Hunter Smith & Davies LLP
1212 North Eastman Road
Kingsport, Tennessee 37664

IN RE: Estate of Shawn Matthew Mckee v.
Dwight M. Bailey, M.D., et al.

Dear Mr. Humphreys

Enclosed please find your copy of the deposition of PAUL PASCHALL M.D., along with the original signature page. As agreed, you will be responsible for contacting the witness regarding signature.

Within 30 days of July 27, 2015, please forward errata sheet and original signed signature page to counsel for Plaintiff, Benjamin D. Byrd.

If you have any questions, please do not hesitate to call. Thank you.

Yours,

Kathleen Hamilton, RPR, CRR, CCR
Reporter/Notary

cc: Benjamin Byrd, Esquire

Capital Reporting Company
1821 Jefferson Place, Northwest
Third Floor
Washington, D.C. 20036
(202) 857-3376

E R R A T A S H E E T

Case Name: Estate of Shawn Matthew Mckee v. Dwight M. Bailey, M.D., et al.

Witness Name: PAUL PASCHALL M.D.

Deposition Date: July 13, 2015

Page No.	Line No.	Change/Reason for Change

Signature _____ Date _____

KOOTENAI MEDICAL CENTER
Coeur d'Alene, ID 83814

Patient Name: MCKEE,SHAWN

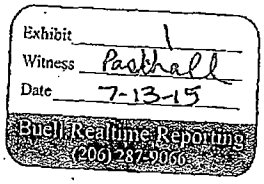
Date of Service: 06/25/2013

HISTORY OF PRESENT ILLNESS: This is a 31-year-old male patient who presents to the emergency department by ambulance with report of rapidly increasing dyspnea with a history of an upper respiratory infection previously treated with antibiotic. He was reportedly tachycardic, rate 142 en route, but his O2 saturations were 96% en route on oxygen. However, on his arrival to the emergency department bay and being taken out of the ambulance, he went out and quit breathing and he was rushed into a room where he was found not to have a pulse or breathing activity and cardiac resuscitation was immediately initiated with chest compressions. The patient has no prior history in the area and I did not have any history from the family on initial evaluation. However, when his wife came, she gave a history that he had been seen a couple of weeks prior and Lebanon, Virginia where he had gone to the hospital for shortness of breath and he was evaluated there and they apparently had recommended a CT scan. However, he was too large for their scanner table and so he had been released with antibiotics with plan to go to another hospital to obtain a CT scan, but he decided he was feeling better and did not want to do that. He subsequently moved from Virginia to here and did so by driving. A few days ago began having some increasing shortness of breath again, but last night it became more severe and he had passed out at least once according to his wife, and today he got markedly worse.

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY: None available initially, except for history of upper respiratory problems. He is a very large, obese male who weighs greater than 400 pounds according to his spouse and certainly appears in size to be over 400 pounds. On presentation, he had no pulses, no respiratory effort. Pupils had already become dilated, but were somewhat reactive.

PHYSICAL EXAMINATION:
GENERAL: He had a quick initial exam.
LUNGS: No air movement. He was being bagged initially and had cardiac compressions.
ABDOMEN: Obese.
EXTREMITIES: Obese, but no obvious acute swelling anywhere.

EMERGENCY DEPARTMENT COURSE: I immediately opted to intubate the patient, but did not require any type of paralyzation. The patient was intubated by me with an 8 tube without difficulty on first attempt, had good color change on the telemetry device and then he was actively back. Initially, he had some agonal respirations. The patient had lines established quickly. He was given IV epinephrine. He got a pulse step back briefly a couple times, but then his rhythm deteriorated. I was able to get an EKG before it deteriorated and it showed a right bundle-branch block. There were some P waves, but not entire strip. The resuscitative efforts were carried out with ongoing compressions and bagged respirations. Multiple doses of epinephrine and a blood gas obtained from the right femoral puncture that was done by me with a Betadine prep. I was able to get a blood gas which gave me electrolytes as well. The pH was 6.974, pCO2 of 67.4, pO2 of 53. The sodium was normal, potassium was 5.08, calcium 4.5, chloride 106, glucose 307. The patient had a normal _____ and hemoglobin. The patient was given bicarb x2 and ongoing epinephrine doses, but he deteriorated into a bradycardic PA rhythm. Ultrasound was placed on his chest and he had no significant cardiac contractility. No evidence of a pericardial effusion was seen. The resuscitative efforts were initiated at 9:43 at his arrival and were discontinued at 10:16 and he was in agonal rhythm at that time. The patient's labs had been drawn as part of this process and revealed a white count of 19.9, platelets 412,000. Normal hemoglobin and hematocrit. His PT and PTT were within expected limits. D-dimer was elevated at 32.6 Chemistries: Creatinine was 1.5, anion gap was 19. AST of 49, ALT of 75, myoglobin 191 and troponin 0.08.



EMERGENCY DEPARTMENT DIAGNOSIS: Cardiopulmonary arrest, unsuccessful resuscitative efforts with the patient being coded over 30 minutes and being urgently and early able to get the patient intubated had IV access early in his presentation. The surrounding history, his weight, and symptomatology also suggest the probability is fairly high that he had a pulmonary embolus. I discussed the patient's findings and history with Deb Wilkey, Coroner. She plans to have a POST done. I also

spent time discussing with the wife the resusoitative efforts and history, and the patient expired at 10:16 a.m.

Paul F. Paschall, MD

PFP:jco

Job ID:1703434 Doc ID:1961294
D:06/25/2013 13:46:12 T:06/25/2013 14:13:04

<Electronically signed by Paul F Paschall MD> 07/13/13 0708

Rpt #: 0625-0259

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